STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012450	A. BUILDING: _____ B. WING _____	06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CENTRE LLC	611 E DOUGLAS RD STE 108 MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS AAAHC Surveyor: 33212 Facility Number: 012450 Type of Survey: State Licensure Off Site AAAHC Accreditation Survey Date of AAAHC On Site Survey - ASC full survey 6/18-19/2015 Date of ISDH off site review - 8/18/2015 Reviewer/Surveyor -Nancy Otten RN, PHNS Based on review of the 6/19/2015 AAAHC Accreditation Survey Report, it has been determined that The Centre,LLC meets the requirements for ASC Licensure in Indiana for 2015.	C 000		